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Director and Health Officer

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### **Substance Abuse Treatment and Control**

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**SAPC BULLETIN NO. #11-01**

January 31, 2011

To: Family Dependency Drug Court Executive Directors and Clinical Directors

From: John Viernes, Jr., Director *John Viernes, Jr. /s/*  
Substance Abuse Prevention and Control

SUBJECT: **REQUEST FOR EXTENDED TREATMENT**

This is to inform you that effective immediately, all requests for extended treatment under the Family Dependency Drug Court program must be based upon the clinical treatment needs of the patient. The duration of any individual's treatment, hereunder, shall not exceed twelve months without the prior written approval of the Substance Abuse Prevention and Control (SAPC) Director, or his/her designee. Programs must have approval documentation on file before the additional treatment is provided. Additionally, providers must seek approval from the presiding Judicial Officer and treatment team members.

A Request for Extended Treatment form (Attached) should be used to communicate this request. Please fax the form to your agency's SAPC Contract Program Auditor at (626) 299-7226.

If you have any questions or need additional information, please contact your assigned Contract Program Auditor or SAPC's helpline at (888)742-7900, Monday to Friday, from 8:00 a.m. to 5:00 p.m.

JV:tkd

P:/Assign10-11/DDC

Attachment

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
SUBSTANCE ABUSE PREVENTION AND CONTROL

REQUEST FOR EXTENDED TREATMENT  
FAMILY DEPENDENCY DRUG COURT

**PROVISIONAL APPROVAL**

DATE OF REQUEST: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

CONTACT PERSON NAME/PHONE: \_\_\_\_\_

COURT CASE NUMBER: \_\_\_\_\_ PROGRAM CASE NUMBER \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_ RESIDENTIAL/OUTPATIENT (CIRCLE)

CLINICAL JUSTIFICATION:  
\_\_\_\_\_  
\_\_\_\_\_

(ATTACH APPROVAL FROM DEPENDENCY COURT)

TREATMENT EXTENSION REQUESTED: *(please list in months)* \_\_\_\_\_

**FINAL DETERMINATION**

DOCUMENTATION SUPPORTS NEED FOR EXTENSION: YES \_\_\_\_\_ NO \_\_\_\_\_

APPROVAL: \_\_\_\_\_

DENIAL: \_\_\_\_\_

REASON FOR DENIAL: \_\_\_\_\_  
\_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
CONTRACT PROGRAM AUDITOR

\_\_\_\_\_  
DATE

*Form may be faxed to the attention of your Contract Program Auditor, fax: (626) 299-7226.*